

		FOR BHF USE					

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**2017**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2017)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0036749</u></p> <p><b>Facility Name:</b> <u>Aviston Terrace</u></p> <p><b>Address:</b> <u>349 West First Avenue</u> <u>Aviston</u> <u>62216</u>  Number City Zip Code</p> <p><b>County:</b> <u>Clinton</u></p> <p><b>Telephone Number:</b> <u>( 618) 228-7040</u> <b>Fax #</b> <u>( 618) 228-7002</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>01/01/1991</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501 C (3)</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>630-361-2868</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 C (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/16</u> to <u>6/30/17</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Lawrence A. Manson</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Lawrence A. Manson</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( )
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749 Report Period Beginning: 7/1/16 Ending: 6/30/17

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	3,799			3,799	13
14	TOTALS	3,799			3,799	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 65.05%

**D. How many bed reserve days during this year were paid by the Department?**  
0 (Do not include bed reserve days in Section B.)

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
None

**F. Does the facility maintain a daily midnight census?** Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 01/01/1991

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 01/01/1991 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 6/30/2017 Fiscal Year: 6/30/2017

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 7/1/16 Ending: 6/30/17

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	19,234	1,626	1,238	22,098		22,098		22,098		1
2	Food Purchase		19,607		19,607		19,607		19,607		2
3	Housekeeping		1,043		1,043		1,043	50	1,093		3
4	Laundry		1,710		1,710		1,710		1,710		4
5	Heat and Other Utilities			15,795	15,795		15,795		15,795		5
6	Maintenance	15,707	939	4,504	21,150		21,150	2,698	23,848		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>34,941</b>	<b>24,925</b>	<b>21,537</b>	<b>81,403</b>		<b>81,403</b>	<b>2,748</b>	<b>84,151</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	195,390	4,485	6,280	206,155		206,155		206,155		10
10a	Therapy										10a
11	Activities		886	62	948		948		948		11
12	Social Services			828	828		828		828		12
13	CNA Training										13
14	Program Transportation			2,502	2,502		2,502		2,502		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>195,390</b>	<b>5,371</b>	<b>11,472</b>	<b>212,233</b>		<b>212,233</b>		<b>212,233</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	10,040		135,509	145,549		145,549	(135,509)	10,040		17
18	Directors Fees							4,284	4,284		18
19	Professional Services			4,268	4,268		4,268	6,687	10,955		19
20	Dues, Fees, Subscriptions & Promotions			609	609		609	1,716	2,325		20
21	Clerical & General Office Expenses	3,901	1,744	10,134	15,779		15,779	66,114	81,893		21
22	Employee Benefits & Payroll Taxes			74,609	74,609		74,609	11,027	85,636		22
23	Inservice Training & Education			1,237	1,237		1,237		1,237		23
24	Travel and Seminar			147	147		147	1,342	1,489		24
25	Other Admin. Staff Transportation			1,211	1,211		1,211	1,075	2,286		25
26	Insurance-Prop.Liab.Malpractice			8,619	8,619		8,619	564	9,183		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>13,941</b>	<b>1,744</b>	<b>236,343</b>	<b>252,028</b>		<b>252,028</b>	<b>(42,700)</b>	<b>209,328</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>244,272</b>	<b>32,040</b>	<b>269,352</b>	<b>545,664</b>		<b>545,664</b>	<b>(39,952)</b>	<b>505,712</b>		<b>29</b>

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Aviston Terrace

#0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			4,914	4,914		4,914	11,949	16,863			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,019	30,019		30,019	13,269	43,288			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							2,247	2,247			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			34,933	34,933		34,933	27,465	62,398			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,932		3,932		3,932		3,932			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,203	30,203		30,203		30,203			42
43	Other (specify):* <b>Disallowed Costs</b>											43
44	<b>TOTAL Special Cost Centers</b>		3,932	30,203	34,135		34,135		34,135			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	244,272	35,972	334,488	614,732		614,732	(12,487)	602,245			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,257	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(22,744)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (12,487)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (12,487)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Aviston Terrace

ID# 0036749

Report Period Beginning: 7/1/16

Ending: 6/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed HO Costs	\$ (25,424)	43	1
2	Expense Building Improvements under \$2,500	2,680	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(22,744)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	50	0	0	0	0	0	0	0	0	0	50	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,680	18	0	0	0	0	0	0	0	0	0	2,698	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>2,680</b>	<b>68</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,748</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(135,509)	0	0	0	0	0	0	0	0	(135,509)	17
18	Directors Fees	0	4,284	0	0	0	0	0	0	0	0	0	4,284	18
19	Professional Services	0	6,687	0	0	0	0	0	0	0	0	0	6,687	19
20	Fees, Subscriptions & Promotions	0	1,716	0	0	0	0	0	0	0	0	0	1,716	20
21	Clerical & General Office Expenses	0	66,114	0	0	0	0	0	0	0	0	0	66,114	21
22	Employee Benefits & Payroll Taxes	0	11,027	0	0	0	0	0	0	0	0	0	11,027	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,342	0	0	0	0	0	0	0	0	0	1,342	24
25	Other Admin. Staff Transportation	0	1,075	0	0	0	0	0	0	0	0	0	1,075	25
26	Insurance-Prop.Liab.Malpractice	0	564	0	0	0	0	0	0	0	0	0	564	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>92,809</b>	<b>(135,509)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(42,700)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>2,680</b>	<b>92,877</b>	<b>(135,509)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(39,952)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aviston Terrace# 0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	10,257	1,692	0	0	0	0	0	0	0	0	0	11,949	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	13,269	0	0	0	0	0	0	0	0	0	13,269	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	2,247	0	0	0	0	0	0	0	0	0	2,247	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>10,257</b>	<b>17,208</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>27,465</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(25,424)	0	25,424	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(25,424)</b>	<b>0</b>	<b>25,424</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(12,487)</b>	<b>110,085</b>	<b>(110,085)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(12,487)</b>	<b>45</b>



**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Progressive Housing, Inc</u>	<u>100</u>	<u>See Pg 6-Supp</u>		<u>See Pg 6-Supp</u>		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>3 Housekeeping</u>	\$	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	\$ <u>50</u>	\$	<u>50</u>   1
2	V	<u>6 Maintenance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>18</u>		<u>18</u>   2
3	V	<u>18 Director Fees</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>4,284</u>		<u>4,284</u>   3
4	V	<u>19 Professional Services</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>6,687</u>		<u>6,687</u>   4
5	V	<u>20 Dues, Fees, Subs and Promotions</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,716</u>		<u>1,716</u>   5
6	V	<u>21 Clerical and General Office</u>	<u>36</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>66,150</u>		<u>66,114</u>   6
7	V	<u>22 Employee Benefits</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>11,027</u>		<u>11,027</u>   7
8	V	<u>24 Travel and Seminar</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,342</u>		<u>1,342</u>   8
9	V	<u>25 Auto Expense</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,075</u>		<u>1,075</u>   9
10	V	<u>26 Insurance</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>564</u>		<u>564</u>   10
11	V	<u>30 Depreciation</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>1,692</u>		<u>1,692</u>   11
12	V	<u>32 Interest</u>	<u>125</u>	<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>13,394</u>		<u>13,269</u>   12
13	V	<u>35 Equipment Rental</u>		<u>Progressive Housing, Inc.</u>	<u>100.00%</u>	<u>2,247</u>		<u>2,247</u>   13
14	Total		\$ <u>161</u>			\$ <u>110,246</u>	\$ *	<u>110,085</u>   14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	43 Non-Allowable Expenses		Progressive Housing, Inc.	100.00%	\$ 25,424	\$ 25,424	15
16	V	17 Administrative	135,509	Progressive Housing, Inc.	100.00%		(135,509)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$ 135,509			\$ 25,424	\$ * (110,085)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Sparta Terrace	Sparta	Progressive			1
2			Taylorville Terrace	Taylorville	Housing, Inc.	Olympia Fields	ICF/DD Provider	2
3			Ellner Terrace -closed	Evansville	Progressive Careers			3
4			Briarbrook Place	East Peoria	& Housing	Steger	Workshop	4
5			Harris Place	East Peoria	Progressive Careers			5
6			Joshua Manor	Hoyleton	& Housing	Waltonville	Workshop	6
7			Terra Estates-closed	Hoyleton	Progressive Careers			7
8			Park Place	Pana	& Housing	Mt Vernon	Workshop	8
9			Cardinal	Woodlawn	Perfection			9
10			Western Gardens	MT. Vernon	Cleaning	Olympia Fields	Housekeeping	10
11			Galaxy	Woodlawn				11
12			Bill Goat Hill	MT. Vernon				12
13			Country Club Hill	Country Club Hills				13
14			Lee street	Country Club Hills				14
15			Baker Street	Country Club Hills				15
16			182nd Street	Country Club Hills				16
17			Osage	Park Forest				17
18			Oakwood	Park Forest				18
19			Blair	Park Forest				19
20			Lowell	Hazelcrest				20
21			Marquette	Park Forest				21
22			Cherry	Park Forest				22
23			Luella	Sauk Village				23
24			Olivia	Sauk Village				24
25			Huron	Park Forest				25
26			Wilshire	Park Forest				26
27			Constance	Sauk Village				27
28			175th Place	Country Club Hills				28
29			Sauganash	Park Forest				29
30								30

Facility Name &amp; ID Number

Aviston Terrace

#

0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edward Childers	Chairman	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	\$ 564	L18,C8	1
2	Orland Bauer	Treasurer	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	2
3	Robert Bauer	Secretary	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	3
4	Shawn Jeffers	Vice Chairman	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	4
5	Cora Flota	Director	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	5
6	Edward Copeland	Director	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	6
7	Eileen Mullin	Board Member	Board Member	None	8,917	3Hrs/MTG	1.00	Dir. Fees	564	L18,C8	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,948		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/16

Ending: 6/30/17

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Progressive Housing, Inc.  
 Street Address 20180 Governors Dr., Suite 300  
 City / State / Zip Code Olympia Fields, IL 60461  
 Phone Number ( 708) 283-1530  
 Fax Number ( 708) 283-2470

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Housekeeping	Bed Capacity/Specific Alloc.	263	29	968	16	\$ 50	1
2	6	Maintenance	Bed Capacity/Specific Alloc.	263	29	303	16	18	2
3	18	Director Fees	Bed Capacity/Specific Alloc.	263	29	72,251	16	4,284	3
4	19	Professional Services	Bed Capacity/Specific Alloc.	263	29	117,723	16	6,687	4
5	20	Dues, Fees, Subs and Promotions	Bed Capacity/Specific Alloc.	263	29	29,301	16	1,716	5
6	21	Clerical and General Office	Bed Capacity/Specific Alloc.	263	29	1,117,820	16	66,150	6
7	22	Employee Benefits	Bed Capacity/Specific Alloc.	263	29	186,014	16	11,027	7
8	24	Travel and Seminar	Bed Capacity/Specific Alloc.	263	29	24,967	16	1,342	8
9	25	Auto Expense	Bed Capacity/Specific Alloc.	263	29	18,123	16	1,075	9
10	26	Insurance	Bed Capacity/Specific Alloc.	263	29	9,561	16	564	10
11	30	Depreciation	Bed Capacity/Specific Alloc.	263	29	28,653	16	1,692	11
12	32	Interest	Bed Capacity/Specific Alloc.	263	29	214,829	16	13,394	12
13	35	Equipment Rental	Bed Capacity/Specific Alloc.	263	29	43,864	16	2,247	13
14	43	Non-Allowable Expenses	Bed Capacity/Specific Alloc.	263	29	218,508	16	25,424	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,082,885	\$ 949,691	\$ 135,670	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Aviston Terrace

# 0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Il Health Facility Auth Bond		X	Facility Purchase	Varies	03/09/06	\$ 941,465	\$ 764,464	08/15/26	6.7500	\$ 28,472	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 941,465	\$ 764,464			\$ 28,472	9						
<b>B. Non-Facility Related*</b>																		
10								Amortization			1,547	10						
11								Home Office Allocation			13,394	11						
12								Interest Income Offset-HO			(125)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 14,816	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 941,465	\$ 764,464			\$ 43,288	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2016	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2012		8
	2013		9
	2014		10
	2015		11
	2016		12
<b>N/A - Not for profit entity</b>			
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2016 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' PREPARATION REPORT

# 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aviston Terrace COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036749

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**



Facility Name & ID Number Aviston Terrace

# 0036749 Report Period Beginning:

7/1/16 Ending:

6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick/Siding Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Rows include Facility (26,400 sq ft, 1991, \$20,000), Allocated from Home Office (6,834), and TOTALS (26,400, \$26,834).

SEE ACCOUNTANTS' PREPARATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1991	1986	\$ 432,500 *	\$	40	\$ 10,413	\$ 10,413	\$ 284,618	4
5			2012	(15,972)					(6,636)	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Expand Bedroom		1991	1,862		15			1,862	9
10	Celing Light Fixtures		1993	536		15			536	10
11	Sprinkler System		1996	936		15			936	11
12	Sprinkler System		1998	1,274		15			1,274	12
13	Bathroom Toilets		2001	1,349		15			1,349	13
14	Bathroom Tiles		2001	2,720		15			2,720	14
15	Bathroom Tiles and Drywall		2001	2,540		15	16	16	2,540	15
16	Sprinkler System		2004	4,614		15	308	308	4,181	16
17	Sprinkler System		2004	900		15	60	60	760	17
18	Furanace Upgrade		2005	1,623		15	108	108	1,333	18
19	Ohio Valley Sprinkler Air Compressor		2005	1,994		15	133	133	1,563	19
20	New A/C		2006	1,014		15	68	68	752	20
21	Living Room Carpet		2007	1,185		15	79	79	823	21
22	Gazebo		2007	1,796		15	120	120	1,149	22
23	Alarm System Upgrade		2008	1,529		15	102	102	960	23
24	Concrete Sidewalk		2008	2,000		15	133	133	1,120	24
25	Flooring - Zickel		2010	3,731		15	249	249	1,826	25
26	New Roof (Gross of Write Off of Old Roof-See Line 5)		2012	14,919		15	994	994	4,722	26
27	Water Heater		2012	4,798		15	320	320	1,474	27
28	Install and paint new steel doors		2014	1,820		15	121	121	344	28
29	New A/C unit		2015	1,692		15	113	113	254	29
30										30
31										31
32	Financial Statement Depreciation				4,914			(4,914)		32
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42		11,751			320	320		42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 483,111	\$ 4,914		\$ 13,657	\$ 8,743	\$ 310,460	70

SEE ACCOUNTANTS' PREPARATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 18,926	\$	\$ 1,834	\$ 1,834	5-10 Yrs	\$ 15,562	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	21,750				5-10 Yrs	21,750	73
74	Allocated from Home Office	22,205		1,222	1,222		18,863	74
75	TOTALS	\$ 62,881	\$	\$ 3,056	\$ 3,056		\$ 56,175	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1998 Astro Van	2004	\$ 4,000	\$	\$	\$	5	\$ 4,000	76
77	Facility Use	Fuel Pump	2008	934				5	934	77
78	Facility Use	2008 Chrysler Van	2008	18,328				5	18,328	78
79	Allocated from Home Office			851		150	150			79
80	TOTALS			\$ 24,113	\$	\$ 150	\$ 150		\$ 23,262	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 596,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,914	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,863	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,949	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 389,897	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning: 7/1/16

Ending: 6/30/17

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 2,247 Description: Allocated from Home Office - postage machine \$92, copier \$1,360, storage \$795

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				3,932		3,932	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	3,932		\$ 3,932	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Aviston Terrace

# 0036749

Report Period Beginning: 7/1/16

Ending:

6/30/17

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/17

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 41,139	\$ 41,139	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,806 )	93,756	93,756	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,984	5,984	7
8	Accounts Receivable (owners or related parties)	(109,745)	(109,745)	8
9	Other(specify): <u>Reserves/Deposits</u>	80,250	80,250	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 111,384	\$ 111,384	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	26,834	13
14	Buildings, at Historical Cost	42,180	483,111	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	42,241	86,994	16
17	Accumulated Depreciation (book methods)	(40,438)	(389,897)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Loan Costs</u> )	4,223	4,223	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 68,206	\$ 211,265	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 179,590	\$ 322,649	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 13,341	\$ 13,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,255	25,255	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,375	1,375	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	51,579	51,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	30,689	30,689	36
37	<u>Deferred Income</u>	459	459	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 122,698	\$ 122,698	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	764,464	764,464	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Bond Fund</u>	73,513	73,513	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 837,977	\$ 837,977	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 960,675	\$ 960,675	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (781,085)	\$ (638,026)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 179,590	\$ 322,649	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(626,368)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(626,368)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(154,717)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(154,717)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(781,085)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 453,071	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 453,071	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,824	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,824	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,130	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,130	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rental Income</u>	1,990	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,990	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 460,015	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	81,403	31
32	Health Care	212,233	32
33	General Administration	252,028	33
<b>B. Capital Expense</b>			
34	Ownership	34,933	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,932	35
36	Provider Participation Fee	30,203	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 614,732	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(154,717)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (154,717)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 453,071	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 453,071	49

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg 19A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

**Aviston Terrace**  
**0036749**  
**6/30/17**

**SCH 19A**

Schedule XVII  
Page 19

This facility is a Not-For-Profit Under IRC 501C(3)  
and is part of a Consolidated Entity Tax Return.  
Therefore, the Income or Loss cannot be  
traced to the Federal Income Tax Return.

Facility Name & ID Number Aviston Terrace

# 0036749

Report Period Beginning:

7/1/16

Ending:

6/30/17

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	461	475	11,375	23.95
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	1,843	1,905	19,234	10.10
16	Dishwashers				16
17	Maintenance Workers	947	1,079	15,707	14.56
18	Housekeepers				18
19	Laundry				19
20	Administrator	228	279	10,040	35.99
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	124	130	3,901	30.01
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	284	315	5,669	18.00
29	Resident Services Coordinator	832	970	16,597	17.11
30	Habilitation Aides (DD Homes)	13,647	14,730	161,749	10.98
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	18,366	19,883	\$ 244,272 *	\$ 12.29

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	23	\$ 1,238	L1, C3
36	Medical Director	Monthly	1,800	L9, C3
37	Medical Records Consultant			
38	Nurse Consultant	Monthly	489	L10, C3
39	Pharmacist Consultant	Monthly	1,378	L10, C3
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant			
44	Activity Consultant	1	62	L11, C3
45	Social Service Consultant	15	828	L12, C3
46	Other(specify) <u>Dental</u>	Monthly	4,073	L10, C3
47	<u>Psychology</u>	Monthly	70	L10, C3
48				
49	TOTAL (lines 35 - 48)	39	\$ 9,938	

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	50
51	Licensed Practical Nurses	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' PREPARATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Christina Durbin	Administrator	0	\$ 9,472	Workers' Compensation Insurance	\$ 19,899	IDPH License Fee	\$	
Karla Rogers	Administrator	0	568	Unemployment Compensation Insurance	7,727	Advertising: Employee Recruitment		
				FICA Taxes	18,302	Health Care Worker Background Check (Indicate # of checks performed <u>2</u> )	70	
				Employee Health Insurance	23,543	Patient Background Checks		
				Employee Meals	3,936	Hiring Expense	172	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Fees	367	
				Life Insurance	336			
				Other Employee Benefits	866			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 10,040			Allocated from Home Office	1,716	
B. Administrative - Other				Allocated from Home Office				
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)		\$ 85,636		
Allocated from Progressive Housing, Inc.			\$ 135,509				Less: Public Relations Expense ( )	
							Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 135,509				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,325
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Paychex	Payroll Service		\$ 1,891				Out-of-State Travel	\$
Paycor	Payroll Service		1,762	N/A				
Benetrac	Payroll Service		275				In-State Travel	60
MyStaffingPro	Payroll Service		107					
Sheakley Paysystems	Payroll Service		233				Seminar Expense	87
							Allocated from Home Office	1,342
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 4,268	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,489

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,478 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,203  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' PREPARATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,936 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 52%
  - d. Have vehicle usage logs been maintained? Adequate records have been maintained.
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
  - g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Heinold-Banwart, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees